CHAPTER FIVE
BUYING AND USING 'REAL BEDS'

Buying King's Fund Beds

The complex purchasing and supply systems operating in the NHS from its inception have received rather scant attention from historians of medical equipment and of the Health Service itself.[1] As ultimate holders of the purse strings (bar the Treasury), the MOH (from 1968 the DHSS) stood at the top of a purchasing structure which involved their own Supplies Division, the Regional Hospital Boards, Hospital Management Committees and administrators and, at the grass roots, hospital supplies officers.[2] Prior to 1948, hospital purchasing in the voluntary sector was often in the hands of the matron's office. Supplies for local authority hospitals were generally organised from the Town Hall and subject to municipal contracting arrangements. Some local authority officials had specialised in the area of hospital supplies and it was from their ranks that many NHS supplies officers were drawn.[3] The precise duties of supplies officers varied

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[1] Exceptions are historical studies of equipment produced by authors based in health economics or health policy. For example, B. Stocking and S. Morrisson, *The Image and the Reality: a case study of the impacts of medical technology*, Oxford, Nuffield Provincial Hospitals Trust, 1978 includes discussion of purchasing structure in its account of the diffusion of CT scanners in Britain.

[2] In 1947 the MOH took over health related supplies from the wartime Ministry of Supply and the Board of Trade. A Hospital Supplies Division was created at the Ministry in 1951. In 1968 the DHSS took on the divisional structure of the MOH unchanged.

[3] 'Hunt-Charter for the Future?', *British Hospital Journal and Social Service Review*, June 23, 1967, pp.1165-6:1165.

between hospitals and hospital groups. Some spent their time 'haggling over the price of potatoes', whereas others were often responsible not only for purchasing, but for choosing, a very substantial proportion of hospital equipment. The Ten Year Plan entailed considerable expenditure on equipping and fitting out the new District General Hospitals. Additional funding for the programme in 1965 meant that, with annual capital expenditure running at £65 million, approximately seven and a half million would be spent on furnishings and equipment, most of it by supplies officers.[4] Their proper status, training and career structure was the subject of increasing attention during the 1960's. Editorials appeared in hospital service journals with titles such as *The Supplies Officer - Where does he stand?* [5] From 1964 the Association of NHS Supplies Officers ran an annual summer school which supplemented courses already run by some RHBs.[6] The Messer Report's recommendation of six years earlier, that supplies should be dealt with 'by a specialist officer' was much quoted.

Manufacturers were not slow to appreciate the key, though as yet relatively lowly, position of this group, who were highly influential in deciding which goods ever made it into the hospital setting. By the 1970's, advertisements in health service journals regularly targeted the supplies officer and alluded, albeit covertly, to his risen status. One series, put out by the paper disposables firm, Kimberly-Clark, featured spoof Mills and Boon style storylines and illustrations in which the handsome, white coated

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[4]P.W. Terry, 'Furniture for the New Hospital', *British Hospital Journal and Social Service Review*, March 26, 1965, pp.563-4:563.

[5]'The Supplies Officer - Where Does He Stand?', *British Hospital and Social Service Journal*, July 10, 1974, pp.953-4.

[6]J.E.O. Smith, Better training for NHS supplies staff, *Health and Social Service Journal*, February 14, 1976, p.229.

(male) hero of the (female) nurses was no longer the doctor, but the supplies officer.[7] Journals beyond the health service field began to take notice of hospital supplies. In 1967, *Design* carried an article entitled *Purchasing — a word that stands for seven million pounds a year to re-equip Britain's hospitals,* which asserted that 'the supplies officer is the man in the hot seat'.[8] It went on to outline the various types of contract issued in the NHS: central, regional and local, thereby highlighting a problem which had surfaced perennially at the Ministry of Health since 1948. Supplies officers worked for HMCs. Ever vigilant of their independence, HMCs were traditionally wary of regional organisation. As the civil servants concerned with supplies were always warning each other, 'HMCs are jealous of their rights. They are suspicious of the extension of group contracting, particularly if it is stimulated by the RHB.'[9] Apart from in a few regions, which had what the Ministry regarded as model authorities, regional contracting had never got off the ground.[10]

The Hospital Plan, however, was organised at regional level. This regional control was far more evident than in the preceding housing and

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[7]See, for example ' "The whole hospital was saying that I roughed up the nurses" ' *British Health and Social Service Journal,* November 8, 1975, pp.2504-2505. The 'roughing up' was caused by inferior quality paper towels, and rectified by a change to Kimberly-Clark's supposedly softer brand, but the term reinforced the racier stereotyping portrayed in the comic strip style art work of the advertisement. Barbie doll nurses pouted and the young supplies officer, with hair curling over the turned up collar of his white coat, preened.

[8]W. Bowring, 'Purchasing - a word that stands for seven million pounds a year to re-equip Britain's hospitals', *Design*, 207, pp.59-61.

[9]Davies to Hunt, 16.1.61, MH136/17.

[10]'RHBs fall into two classes . . . Leeds, East Anglia, Wessex, work mainly on a regional basis, the rest on an area contracting basis', Davies to Howes, Supply Division internal memo, 15.7.60, MH136/17. 'Leeds RHB . . . all in all appears to be a model one . . . joint contracting well established as early as 1949 ', Clair to Sutherland, probably July 1960. MH136/17.

education programmes, which were administered centrally with responsibility delegated to local authorities. Apart from a 'guiding hand and an approvals procedure', central government, in the form of the MOH, intended to let the RHAs get on with it.[11] It was this background, together with the embarrassing censures of the Public Accounts Committee, that led to the setting up of the Hunt Committee on the Organisation of Hospital Supplies. The Committee reported in 1966, while Hunt, the Controller of Supplies, was an active member of the King's Fund Working Party on Hospital Beds. Perhaps unsurprisingly, it came out in favour of a reorganisation of the supplies function on an area, rather than hospital group, basis.

It is clear that increasing concern with economising on scant resources gave supplies officers an integral role in obtaining the best possible deals from suppliers. And the context of new hospital building drew them closer to the mainstream of the hospital management structure.[12] For they provided some of the essential input for an activity which came to great prominence in hospital management during the 1960's, as indeed it did in many other forms of administration. This activity was planning; that is, planning as a self-conscious, formalised technique of

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[11]Speaking at the Institute of Work Study Practitioners in April 1967, W. G. Wilson, Assistant Secretary, MOH, 'explained that the new building procedures . . . would place a greater responsibility on the shoulders of the regional boards for planning and controlling their building programmes. The Minister's intention was to withdraw from all detailed appraisal of plans once he had been assured that the proposed scheme met his general policy.' 'Network analysis and hospital planning', *Hospital Management,* June 1967, pp. 310-311:310.

[12]During preparations for the new Charing Cross Hospital in London, for example, the equipment sub-committee of the planning committee set up a working party under the chairmanship of the group Supplies Officer to lay down policy for equipping various units in a pilot scheme. The working party included consultant medical staff and an assistant matron. G.White, 'Charing Cross Hospital Pilot Scheme', *British Hospital Journal and Social Service Review*, May 14, 1965, pp.873-876.

management. The Permanent Secretary at the Ministry of Health, Sir Bruce Fraser, addressed the Royal Institute of Public Administration on 'the long-term administrative problems of planning'.[13] The 1960's saw the creation of planning theorists and planning engineers. The journal *Long Range Planning* began publication in 1968. By the time a 'special adviser to the Chief Secretary of the Treasury' contributed an article in 1971, planning, it seems, was virtually synonymous with management itself. Strategic planning was 'a systematic approach to general management', the same activity in business or in government.'[14] There are issues to be explored about the changing definition of management in the post-war decades which I will not pursue further here. It is clear however that planning came to be considered constitutive of management to a very large degree. The King's Fund Hospital Administrative Staff College defined management as:

(a) The planning and setting of objectives.

(b) Organisation and analysis of available resources, human and financial, to meet the plan.

(c) The management of resources, their use and thus the control and fulfilment of the plan.

(d) The development and training of staff at all levels to meet changing situations.

When the Lycett Green Report on hospital management had appeared in 1963, 'Planned', wrote one commentator, was its 'dominant epithet.'[15]

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[13]'Planning in the Hospital Service', *British Hospital and Social Service Journal,* 27 December 1963, p.1583.

[14]R. J. East, 'Comparison of Strategic Planning in Large Corporations and Government', *Long Range Planning*, June, 1972, pp.2-8.

[15]'The Lycett Green Prescription for Service Health', *British Hospital and Social Service*

Planning was central to management and, in the mid-1960's, 'management' preoccupied the administrative hospital service. 'Who manages what and what is meant by management?' was a typical question in the hospital press.[16] It might be argued that at least the initial success of the King's Fund Bed in the key purchasing loop of supplies officer, manager and HMC (or RHA) had less to do with its physical characteristics than with the obvious economic and organisational appeal of standardisation per se, and also with a less overt attraction inherent in the bed's much publicised 'rational and scientific' method of design. This might have been expected to find favour with some sectors of an audience very much preoccupied with 'rational and scientific' management. Some hospital administrators were in no doubt that the future of hospital management lay with the new management techniques derived from operational research, and had already cooperated with operational research -type projects within their hospitals.

Prior to 1960, a few projects in the Health Service, often supported by the Nuffield Provincial Hospitals Trust, had made explicit use of operational research as a model.[17] A 1960 conference at Magdelen College, Oxford, sponsored by the Trust, marked the start of a period when operational research was vigorously promoted in the NHS, the MOH having been 'alive to the potentialities of the application of scientific method and

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Journal, September 20, 1963, pp.1133-4:1133.

[16]'Committees and Management', *British Hospital and Social Service Review,* August 5, 1966, pp.1441-2.

[17]The earliest explicit reference to the possible use of operational research in health related issues was apparently in a minority report for the Cabinet Working Party on the recruitment of nurses in 1948. G.M. Luck, *Review of O.R. in the Health Services*, London, Institute for Operational Research,1971,p.3.

modern management techniques to the planning and administration of the National Health Service for some time'.[18] The Ministry of Health began systematic support of operational research in the mid 1960's, and the DHSS set up its own Operational Research Group in 1970.

But the applicability of planning, scientific management, or operational research to problems in the Health Service was not immediately obvious to some hospital administrators. According to one Group Secretary:

> Surveys, probes and inquisitions had resulted in lack of confidence between the Ministry of Health and the administrative and clerical staff of hospitals . . . It was unlikely that the new hospitals would be radically different from the old ones, and revolutionary changes in structure would affect the morale on which hospital services depended more than was generally realised.[19]

Sometimes an obvious close connection with the origins of these practices in the military sphere, through the personnel involved or the vocabulary employed, may have brought opposition. 'Operational research is no task for a dilettante' declared Brigadier J D Welch, speaking at a course organized by the Institute of Hospital Administrators in 1963. He went on to outline the 'painful stages' to be gone through: 'pilot work should never be skimped; during the war it had been learnt that time spent on reconnaissance was rarely wasted.'[20]It was hardly surprising that some senior administrators, while accepting that the quality of hospital management was poor, expressed the view that 'the use of management

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[18]Ibid. p.5.

[19]'The Ten Year Plan', *British Hospital and Social Service Journal,* April 19, 1963, p.452 'this was perhaps why enthusiasm for the ten year plan was tempered by the fear of redundancy', he continued.

[20]'Operational Research in the Health Service, Objectives and Methods',*British Hospital and Social Service Review*, April 19, 1963. p.451.

structures based on the army would not improve the quality of treatment.'[21] Nor did the model of a commercial firm seem suitable. Commenting on the fact that the Minister of Health was known to be considering the possibility of establishing some sort of criterion by which hospital expenditure could be assessed against the value of the work done, one senior administrator asked:

> Is the practice of medicine to be treated as an industry? Is the hospital to become a medical factory and the patient a unit of medical material? To what extent are we going to accept standards of industrial management in the administration of a hospital? Where, exactly, are we going?[22]

The notion of service was frequently invoked, as was the impossibility of measuring, or even defining, efficiency or effectiveness in hospitals.[23] An article by the steward of the United Oxford Hospitals, however, identified a more practical issue. Speaking of hospital administration, he wrote that, unlike the situation in industry, where a clear line management structure existed, with 'each grade having the authority and technical knowledge to instruct and guide the one below', the hospital service was fragmented into specialised areas many of which operated autonomously. 'In fact, all the administration can control - is space, staff, supplies and services. These are the only management tools that are to hand.'[24] Space

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[21] Management Services, *British Hospital Journal and Social Service Review*, January 21 1966, pp.121-122:121.

[22] Letter, M.Gruber, *British Hospital and Social Service Journal*, September 13, 1963, p.1114. See also, 'The Tempo of Hospital Care', British Hospital Journal and Social Service Review, June 24 1966, pp.1142-1143: 'Centralisation, increasing size, impersonality of approach and intensive treatment methods introduced in response to a spurious scientism reinforced by pseudo-economics can too easily be carried beyond the point of no return.'

[23] 'Business efficiency and hospital service', *Hospital Management, Planning and Equipment*, 30, no. 376, November 1967, p. 513.

[24] E. Holt, 'Administration, Finance and Supplies', *British Hospital Journal and Social Service Review*, April 2, 1965, p.614.

was 'a very long term sort of control', with opportunities for new building relatively infrequent and even the reallocation of space a 'frustrating and slow business'. The control of staff offered:

> . . . slightly more but even here except for directly administrative and maintenance people, administration offers little effective control over what people actually do once they have been allocated. Supplies and services, and especially supplies, are by far the most controllable things we can find.

Herein lay the attraction of supplies, and the supplies function, to those administrators who wished to introduce new management techniques or who at least felt they should be on the right side when it came to the contrast between the 'guesswork of the old school and the new scientific management based on sound principles and accurate information'.[25] Supplies were manageable. I shall return to this issue in Chapter Six.

Using King's Fund Beds

If the purchase of King's Fund Beds principally involved supplies officers and administrators, immediate users were a different group. The question of how well King's Fund Beds succeeded for them is difficult to answer. In the Chase Farm trials, objective recording of how often attention was given, adjustments were used, or what position bed elements were in at randomly selected times, greatly exceeded efforts to solicit opinion, either of nurses or patients. Indeed the recording method which Archer initially favoured would have precluded the observers (all trained nurses) from

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[25]T.R. Bond, 'Organisation Before Methods', *British Hospital and Social Service Journal*, February 26, 1965, pp. 359-361:359.

assessing whether, when the beds' facilities were used, they were used 'with benefit'.[26] A further objective assessment, the study of energy expenditure by nurses using the beds that was to have been carried out at Edinburgh University, had to be cancelled due to other commitments of the department involved.

An attitude survey of Chase Farm nurses was conducted by a sociologist, but only thirteen had worked with the beds and one nurse refused to answer any questions at all.[27] Their general consensus of opinion was summed up as 'the bed contains some excellent features but they were put together wrongly'. Other sources for nursing opinion are scarce. It was rumoured in December 1965 that 'senior nurses at the Ministry of Health have been making disparaging comments about the prototype'.[28] The prototype was not of course the commercial product, which Agnew worked on with Nesbit-Evans. This received a very favourable report from the charge nurse of the Royal Berkshire Hospital ward where it was trialled when he was invited to speak at the launch conference held by the King's Fund.[29]

Nursing journals reported the publication of the specification with cautiously favourable editorial comment, but as the bed became less newsworthy, references in the press were fewer. Once their version of the King's Fund Bed was on the market, Nesbit-Evans agreed to keep a log of

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[26]Interview, Kenneth Agnew, 9.8.00. Archer was apparently dissuaded from this course by the work study officer, Harrison.

[27]North East Metropolitan Regional Hospital Board Work Study Unit, Report No 81, *Attitudes of Patients and Staff to Hospital Bedsteads*, undated but almost certainly 1967.

[28]AAD/1989/9, Job 13, Archer to Howes, 30.12.65

[29]John Southwood, 'Nesbit-Evans King's Fund bedsteads in use', *Hospital Management*, November 1967, pp. 538-540.

complaints and suggestions, but this cannot be traced. A few nurses wrote to the King's Fund, or the hospital journals, asking for the opinion of colleagues who had experience of the beds. Some only possessed one King's Fund Bed on their ward. Unusually, one matron fought hard to get her hospital equipped with King's Fund Beds then wrote to the Fund asking how she might 'demonstrate by statistical evidence that the choice was a wise one'.[30] In general however, little evidence is to be had of how well the new beds served nurses' needs, whether as defined by the team or otherwise, and little formal effort seems to have been made to find out. When the bed became commercially successful the answer was perhaps regarded as self evident; or else the question became somewhat irrelevant.

Without doubt, the methods used to draw up the specification had focused on nurses, and on a strictly limited decision space in which the behaver/ tool user occupied central place. This was a consequence of them involving, wherever possible, objective observation of the man-tool-environment system. Establishing needs was best done by observing behaviour, their empircal counterpart. The greatest amount of behaviour that went on around a hospital bed was that of nurses (apart from patients, whose relative exclusion I shall consider below). It was an inevitable consequence of this assumption that the methods employed, and the resultant specification, prioritised nurses needs, largely behaviourally defined. This prioritisation (though not its origins) was acknowledged in a review of the King's Fund Bed specification conducted by the Fund in 1998.[31] Perhaps influenced by Doreen Norton, the RCA team were

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[30] AAD/1989/9, Job 15, Weston to Agnew, 29.10.69.

[31] This prioritisation (but not its theoretical origins) was acknowledged in the review of the King's Fund Bed conducted by the Fund in 1998, 31 years after publication of the original specification. Bruce Archer was a member of the review body. Mitchell et al., *Better Beds*

sympathetic to the nursing cause.[32] A research nurse who had devoted considerable effort to studying equipment in wards, she was firmly of the opinion that 'nurses are the only authority qualified to say what is required of basic ward equipment for total patient care. This fact must never be lost sight of.' [33] It was however a prior decision to have a nurse on the team, as the only expert from beyond the design professions. No medical personnel were included in the core team. It seems likely that Archer's early discussions with the MOH had impressed upon him the obstructive role of consultants' personal preferences in impeding progress on standardisation. He had certainly formed this view by 1964, when he said, in a talk entitled 'Why are hospitals so difficult to design for?' that 'Hospital staffs, in particular doctors, were laymen in engineering and design matters but they did not adjust themselves to this fact'.[34] Archer tended to regard their views as obscuring nurses 'real needs'. Did the bed serve those needs better ?

A focus on behaviour rather than cognition produced the occasional 'mismatch'. To avoid the apparently time-wasting activity of rearranging pillows, Agnew provided straps to retain them against the backrest of the RCA prototype. It was later asserted that experienced nurses regarded 'pillow plumping' as an opportunity for discreet, close-up assessment of a patient's condition.[35] And a cleaning supervisor said that her staff would

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for Health Care, 1998.

[32]Interview, Gillian Patterson, 29.1.98.

[33]Doreen Norton, 'Give us the tools . . .', *British Hospital and Social Service Journal*, 4 September, 1964, pp1272-1273:1272.

[34] 'Why are hospitals so difficult to design for?', *British Hospital and Social Service Journal,* December 11, 1964, pp. 1793-1794:1793.

[35]Interview, Gillian Patterson, 29.1.98.

never move a bed that *looked* as heavy as this one. Perhaps more importantly, a focus on use in the limited sense of maximising efficiency of physical effort and minimising injury, ignored the question of whether ward organisation and staffing would allow for use of the facility. Certainly the team seem to have had at times an unrealistic expectation that rather small physical advantages during procedures would induce nurses to expend time and effort raising or lowering the bed. A filmstrip produced at Chase Farm to demonstrate the prototype beds showed a sequence of a nurse altering the height of the bed in order briefly to examine a patient's ear with an auroscope. In the attitude survey of Chase Farm nurses, it was reported that 'in general height adjustment was liked but some day nurses and all night nurses reported that they didn't have time to use it'. While Archer stressed that they were seeking optimal satisfaction of user needs, irrespective of factors such as this, user needs were not constituted entirely, or even largely, at the bedside; nor were decisions to purchase. Given the purchasing structures outlined above, and the position of nurses in relation to these and to the hospital hierarchy generally, it might be questioned whether the extent to which it met their needs, however defined, mattered very much to the commercial success of the bed.

The RCA team had perhaps, like some other design professionals working for the Health Service, overestimated the power of the nurses' voice, whether in support of, or as an obstruction to, change. An architect speaking at the Scottish Hospital Centre in 1967 felt:

> . . . it should be recognised that nursing staff were the main users of space and equipment in hospitals and that their views were likely to present the greatest difficulty in finding uniform and satisfactory solutions.[36]

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[36]'The importance of detail', *Hospital Management*, October 1967, pp.486-488:486.

Some of those inside the hospital service, however, pointed out that nurses appeared to have no views at all. At the same meeting it was noted that 'the nursing profession had tended to be represented by the smallest voice at all levels. Nursing staff should not accept defects but if they were to shout louder, they should also shout clearer.[37]

This comment perhaps encapsulates both the reality of nurses' lack of power in the hospital service and also a widespread perception that this situation was somehow their own fault. The preceding year, in an article entitled *What do you think, Nurse?*, the Group Secretary of East Birmingham HMC commented:

> Nurses are as able as the rest of the hospital community to express their thoughts and feelings; the marriage rate confirms that. Yet who has not recoiled in despair after the attempt to get nurses to express their own opinions about their own hospital? To use today's jargon, why don't they communicate? Ask a nurse for an opinion on some hospital matter and you are likely to get the opinion she thinks her next senior nurse would expect her to give. And it gets worse as you get nearer the top. Nurses seem to be trapped in a system of rank and precedent which they hate but which they perpetuate; they dislike being cut off from other professional workers in the hospital community and yet they consistently maintain and fortify a moat between themselves and the rest of the hospital . . . As a class, nurses seem to have little interest in politics and even less in trade union matters . . . They have a very real understanding of the purpose and value of the work of doctors . . . but they seem to have little realisation of the importance or the difficulties of the work of other people in the hospital team. They may say that they appreciate these difficulties but in fact they regard everyone other than doctors and nurses as people whose work gets in the way of medical and nursing work.[38]

Despite these criticisms, the article was intended 'to point the way to

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[37] Ibid, p.489.

[38] James Elliott, 'What do you think, Nurse?', *British Hospital Journal and Social Service Review*, January 7, 1966, pp. 29-30: 29, 30.

constructive methods . . . of inducing nurses to participate practically in the management of their own hospital.' Even those, like this author, who were sympathetic to nurses' lack of voice, betrayed something of the attitudes which contributed to the situation. The marriage rate of other workers in the health service was seldom alluded to. Nursing recruitment brochures, however, specifically advertised nurse training at this period as 'an ideal preparation for marriage', and a lifelong commitment to nursing was still sometimes referred to as an alternative to marriage.[39] At a Royal College of Nursing meeting following the 1965 recommendation of the Platt Report that entrants to nursing should have four 'O' levels, a speaker felt these should be specified, otherwise it would be 'possible for a candidate to present herself with drawing, needlework, domestic science and religious knowledge'. To loud applause, the principal nursing tutor of a London teaching hospital rejoindered that she 'could see nothing wrong with domestic science and religious knowledge as subjects for a would-be nurse'.[40] The established academic tradition in North American nursing at this period had very little counterpart in Britain.[41] Articles written for nurses by other professionals often adopted a simplified or 'popular' approach. The piece which Irfon Roberts wrote for the *Nursing Times* describing the

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[39]A recruitment brochure produced by the Brompton Hospital, London, current in 1966, asserted 'The wonderful training that the Brompton Hospital gives you will be ideal as a pre-marriage course. ' quoted in: B. Watkin and K.Baynes, 'Nursing School Brochures, Part Two', *British Hospital Journal and Social Service Review*, March 11 1966, pp.453-455:453. This referred to training 'for the Roll'. Intended to relieve more highly trained registered nurses of less technical duties, enrolled nurses were yet another source of controversy in nursing. The Royal College of Nursing worried about 'dilution' of skilled nurses. For hospital administrators and the MOH, enrolled nurses helped ease the nursing shortage.

[40]'Monitor', *British Hospital Journal and Social Service Review*, May 28, 1965, p.963.

[41]The first university nursing studies unit was established at Edinburgh in 1956. Rivett, *From Cradle to Grave*, p.104.

bed project is a case in point. It was couched entirely in question and answer format, and was illustrated with humourous line drawings showing owls perched on hospital beds.[42] And nurses' appearance continued to attract more comment than that of any other hospital group.[43]

The comments about appropriate O levels for nurses were reported in the *British Hospital and Social Service Journal* in 1965. On the same page was a report that the Royal College of Nursing had 'again expressed its concern and regret that there is no statutory obligation on Regional Boards to appoint nurses to Hospital Management Committees'. 'It might be wondered', continued the writer, 'what there is in nurse training which particularly qualifies a nurse for committee membership?'[44]

Nursing representation varied. The matrons of teaching hospitals could expect a close working relationship with the house governor and HMC. Matrons of smaller hospitals, of which there might be several to one hospital group, 'didn't even see a copy of the HMC minutes.'[45] Inevitably, senior matrons of prestigious hospitals tended to represent nursing interests on boards and committees. Their interests were not necessarily those of rank and file nurses. Unlike consultants, matrons were isolated at work, without colleagues of similar standing with whom to discuss issues. The fragmented and divided state of British nurses who, at a stroke, had all

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[42]Irfon Roberts, 'Design of Hospital Bedsteads: some questions and answers', *Nursing Times*, May 13, 1966, pp.632-634.

[43]This remains the case for some historians of the NHS. Rivett describes the situation at the outset of the Service: 'uniform was spotless, shoes shone,dress hems had to be level with the apron . . . Hair was neat, caps were worn and make-up forbidden. The result was stunning.' Rivett, *From Cradle to Grave,* p.21.

[44]'Monitor', *British Hospital Journal and Social Service Review*, May 28, 1965, p.963.

[45]Rivett, *From Cradle to Grave*, p.109.

become employees of the State in 1948, has been described by many authors. The perceived problems with nursing resulted in seemingly endless reviews of recruitment, training, remuneration and the proper role for the nurse; a continuation of the situation identified in 1958 by the editor of the *Nursing Mirror*, who pointed out that there had been no fewer than 20 reports on nursing problems in the preceding 25 years.[46] Division, hierarchy, high wastage leading to rapid turnover, and the entrenched attitudes of other groups to a predominantly female profession, did not make for a powerful voice. 'We would never have dreamed of lobbying for something so expensive', recalled the sister in charge of the ward at Chase Farm Hospital where the RCA prototypes were trialled. 'Yes', replied the Matron, 'you got marks for staying in budget'.[47]

[46]Rivett, *From Cradle to Grave*, p.186.

[47]Interview, Mary Larret and Shirley Lockett, 10.5.99.